Warrior Combat Stress Reset Program – Fort Hood

NAVY AND MARINE CORPS COMBAT & OPERATIONAL STRESS CONFERENCE 2010:
"TAKING ACTION, MEASURING RESULTS"

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WARRIOR COMBAT STRESS RESET PROGRAM

CR DARNALL ARMY MEDICAL CENTER

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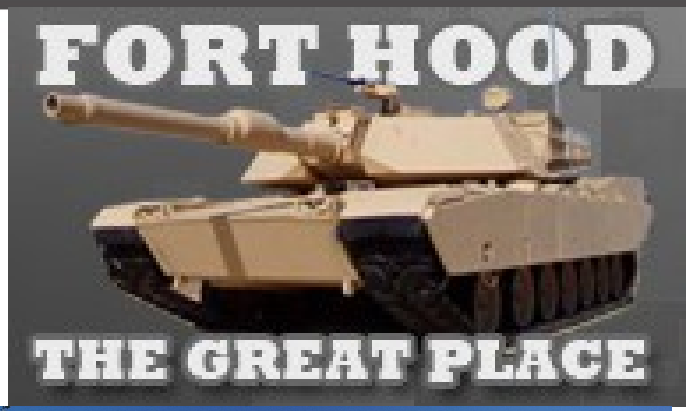

U.S. ARMY MEDICAL DEPARTMENT
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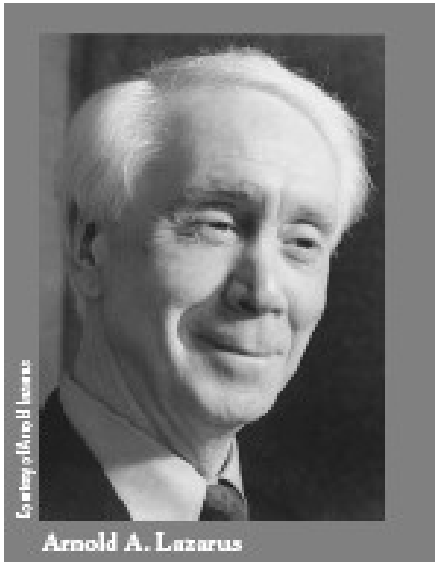
WCSRP Development

- **Local Interest** in innovative treatment of PTSD ~ 2007
  - Fort Bliss R&R Program – 2007
  - CAM programs at Walter Reed
- **Program Development Working Group** (LTC Kathleen Lester)
  - Review of the Fort Bliss program & other treatment models
  - Literature review on PTSD & Treatment
  - Developed multimodal protocol targeting “Hyper-arousal”
  - Developed short-term intense day treatment design
  - Developed Program Evaluation Plan
- **Doors open** at WCSRP - August 2008

Multimodal Model

- Lazarus – Multimodal Behavior Therapy
  - **B**ehaviors
  - **A**ffective response
  - **S**ensory reactio
  - **I**mages
  - **C**ognitions
  - **I**nterpersonal relationships
  - **D**rugs / biological issues & interventions

BASIC-I.D.



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WCSRP Multimodal Approach

- ***Multimodal therapy integrates eclectic approaches in a theoretically thoughtful manner***
- ***Target syndrome (Complex PTSD) deconstructed into components***
- ***All interventions target one or more dysfunctions***
- ***Complex PTSD <u>(Prolonged, multiple trauma events)</u>***
  - ***Prolonged Hyper-Arousal & Autonomic Reactivity***
  - ***Hyper -vigilance***
  - ***Intrusive Thoughts / Images / Memories***

WCSRP Multimodal Model

- **"Hyper-Arousal" = A Core Sx of PTSD**
  - After repeated stress, limbic brain locks 'on' & frontal lobes go "off-line"
  - Early hyper-arousal predicts negative long-term
  - Focal target for initial short-term treatment
- **Continued "Hyper-arousal" > PTSD Spec**
  - Symptoms (mental / physical bracing & reactivi
  - Physiology fails to recover to baseline
  - Avoidance of anything that triggers reactions

- **WCRSP designed specifically for intense multimodal integrative treatment of hyper-arousal symptoms**
- **Groundwork for Treatment of Complex PTSD**

Complex PTSD

- Disorders of Extreme Stress (DES nos) *(van der Kolk)*
- Developmental PTSD *(Herman)*
  - Many soldiers have severe developmental trauma before military
- PTSD with prolonged / repeated trauma
  - Core Symptoms (In addition to hyperarousal, hypervigilance, avoidance and trauma event memories)
    - Emotional dysregulation (like Borderline PD)
    - Dissociation (Altered Consciousness / Flashbacks)
    - Severe Interpersonal problems (Attachment disorders)
- Military PTSD often Complex PTSD

Complex PTSD / DESNOS

- **Self Concept**
  - Helplessness, shame, guilt, stigma
- **Alterations in emotional regulation**
  - Anger, SI, sadness, avoid thinking and talking, numbing
- **Alterations in consciousness**
  - Forgetting, reliving, or detached / dissociated
- **Alterations in relations with others**
  - Attachment disorder, isolation
- **Changes in one's system of meanings**
  - Loss of faith, sense of hopelessness and despair
- **Developmental Trauma Common**

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WCSRP Protocol Summary

- Intensive, 11-week Treatment program
  - Integrated Mind/Body + CAM modalities
    - 3 week intensive day treatment program (N=12 /cohort)
    - Eight weeks of 1:1 & group follow-up sessions
- Reducing Hyper-arousal
- Restoring self-regulation / awareness / control
- Initial Treatment of PTSD Sx
  - Quieting bodies and minds
  - Reduced Avoidance / Triggers / Memories

WCSRP Assumptions

- ***Regulation of arousal***
  - *Resets capacity to integrate experiences*
  - *Reduces emotional & physical reactivity*
  - *Restores baseline responsiveness to Reality*
  - *Self-Regulation skills > self-efficacy and resilience*
  - *Enhances benefit from Cognitive & Behavioral treatment modalities*
- ***Complex synergy of treatments for complex disorder***
- ***All Mind/Body & CAM interventions target one or more components of complex PTSD***

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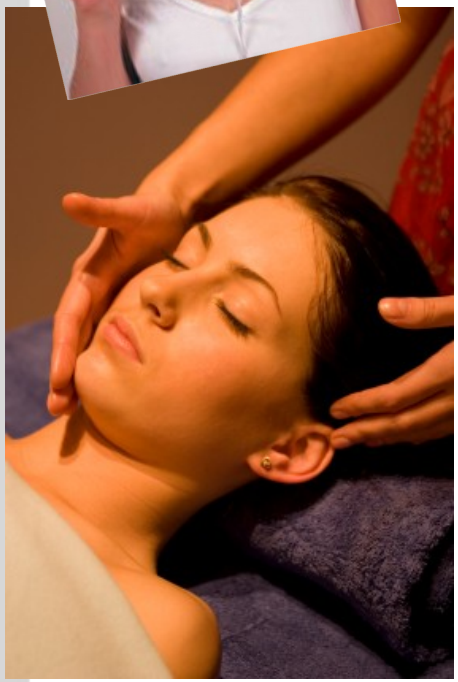
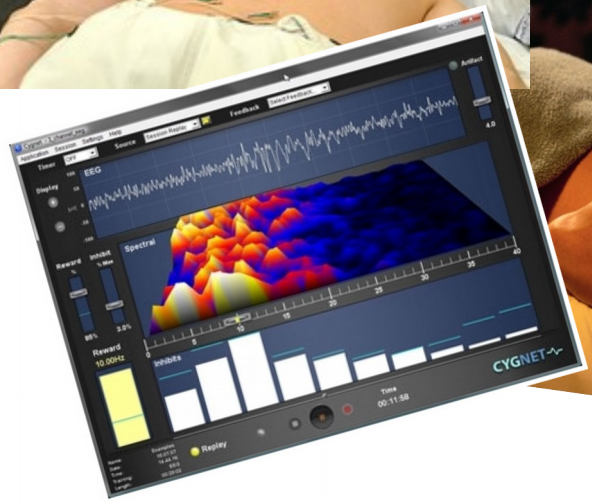
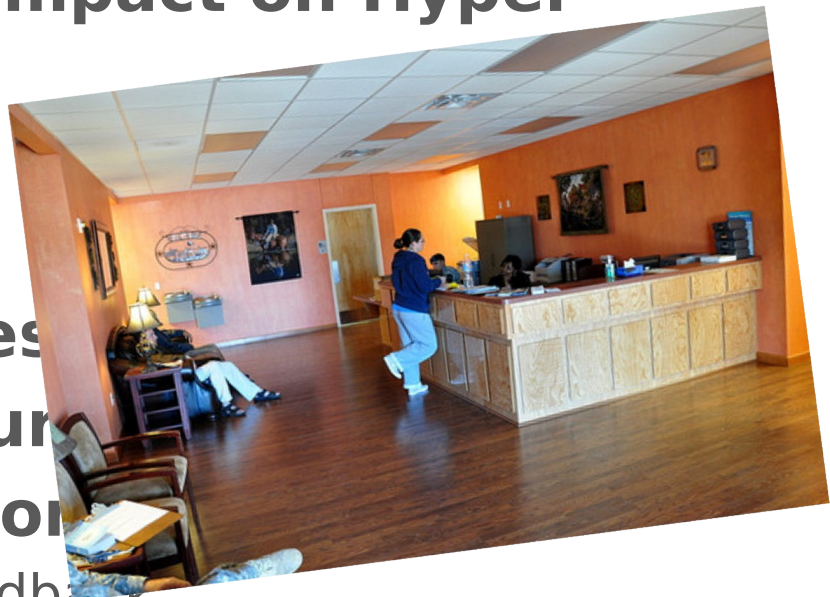




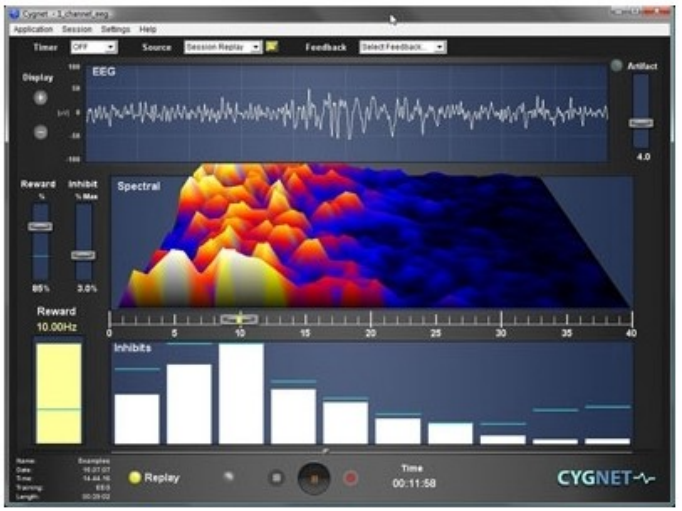
Complementary & Alternative Therapies (CAM)

- **Modalities selected for impact on Hyper-arousal**
- **Massage**
- **Yoga & Tai Chi**
- **Reiki / Bio-field Therapies**
- **Acupuncture / acupressur**
- **Mind/Body Self-Regulation**
  - Breathing, Meditation, Biofeedback
  - Neurofeedback
- **Others** – Sound, Music, Aromatherapy
- **Note: *"Healing Environment"*** concept



Multimodal Integration & Synergy

- Mind / Body Care + CAM Modalities
- Reduce Hyper-arousa
- Decrease Avoidance
- Reduced “Triggers”
- Healing of memories
- Preparation for longer term recovery



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PTSD Treatment Components

- 1) Reduced Hyper-arousal
  - Initial passive induction of quieting
  - Reliable self-regulation skills
- 2) Reduced Avoidance behaviors
  - Combine skills & structured in-vivo tasks
  - CPT / PE Follow-up programs as needed
- 3) Processing of memories & meaning

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WCSRP Modalities

- 1:1 & Process Groups *(4x/Wk)*
- HRV Biofeedback *(Daily)*
- EMDR *(1:1, PRN)*
- Cognitive Tx *(Grp-4x/wk)*
- In-Vivo Exposure *(PRN, 1:1, Self-directed)*
- Neurofeedback *(3-4x/wk as possible)*
- Massage *(1-3/wk)*
- Reiki *(1-3/wk)*
- Acupuncture *(1-2/wk)*
- Reflexology *(1-2/wk)*
- EFT *(Daily, PRN)*
- Yoga *(Daily)*
- Sound Meditation *(2x/wk)*
- CES *(2x/day, PRN at Night)*

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Initial Results

- Soldiers are E-3 to CW-2, N ~ 230 Alumni
- TIS Ave = 11.7 years (range 2-28 yrs)
- PCL-M PTSD Survey (Score > 50 ~ PTSD (Military))
  - Pre (n=51) = 65.7 (range 35-84)
  - Post (n=51) = 54.3 (range 23-83)
  - *-11.4 Difference is statistically significant by ANOVA, p<.00*
- Beck Depression = (-7.7) *p<.00*
- Beck Anxiety = (-5.9) *p<.00*
- Satisfaction (Mean) = 4.15 / 5.0

PCL-M Differences (Pre-Post)

PCL-M Levels				
	Pre #	Post #	Pre%	Post%
<40	1	9	2.0%	17.6%
40-50	6	9	11.8%	17.6%
51-60	9	19	17.6%	37.3%
>60	35	14	68.6%	27.5%
Tot	51	51	100.0%	100.0%

(ChiSq < .000)

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PCL-M Pre/Post Analysis by Item	2009 (n=65)			2010 (n=51)		
** - Related to Hyperarousal*	Mean Decrease	Std. Deviation	Sig(2-Tail)	Mean Decrease	Std. Deviation	Sig(2-Tail)
Total PCL-M	5.88	14.71	0.002	11.31	13.36	0.00
Intrusive Memories	0.17	1.01	0.181	0.43	1.12	0.01
Dreams	0.29	0.89	0.013	0.49	1.08	0.00
Flashbacks	0.25	1.19	0.099	0.57	1.02	0.00
Upset / Reminded *	0.08	1.23	0.615	0.57	1.17	0.00
Physical Rx*	0.22	1.15	0.137	0.49	1.39	0.02
Avoid Think/Talk/Feel*	0.49	1.44	0.008	0.59	1.22	0.00
Avoiding activities	0.25	1.51	0.194	0.73	1.30	0.00
Memory Loss	0.29	1.48	0.115	0.49	1.46	0.02
Loss of Interest	0.20	1.34	0.232	0.76	1.26	0.00
Distant/Cut off	0.45	1.34	0.009	0.92	1.26	0.00
Emotional Numb	0.35	1.34	0.037	0.76	1.44	0.00
Future Cut Short	0.43	1.33	0.011	0.43	1.30	0.02
Sleep *	0.28	1.21	0.069	0.88	1.03	0.00
Irritable/Anger *	0.71	1.38	0.000	0.96	1.02	0.00
Concentration *	0.52	1.25	0.001	0.82	1.23	0.00
On Guard *	0.49	1.15	0.001	0.69	1.19	0.00
Jumpy *	0.48	1.26	0.003	0.73	1.02	0.00

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WCSRP: Way Forward (Assessment)

- Data Management & Program Evaluation
  - Staff & Database Development / Summer 2010
- Research Projects (One modality Pre-treatment)
  - Acupuncture study (complete in August)
  - Neurofeedback & Q-EEG - FY 2011
  - EMDR/EFT - FY 2011(late)
  - Cortisol, fMRI, Cognitive testing

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WCSRP: Way Forward (Program)

- Add Neurofeedback (FY 2011) **(#1 Goal)**
  - Implement the new version Peniston protocol
- Add Spouse / Family components
- Increase use of EMDR/EFT (Staff Training)
- CPT & PE options in Follow-up Groups
- Target Specific Groups (Homogeneous Cohorts)
  - Continued Service vs. MEB/Retire

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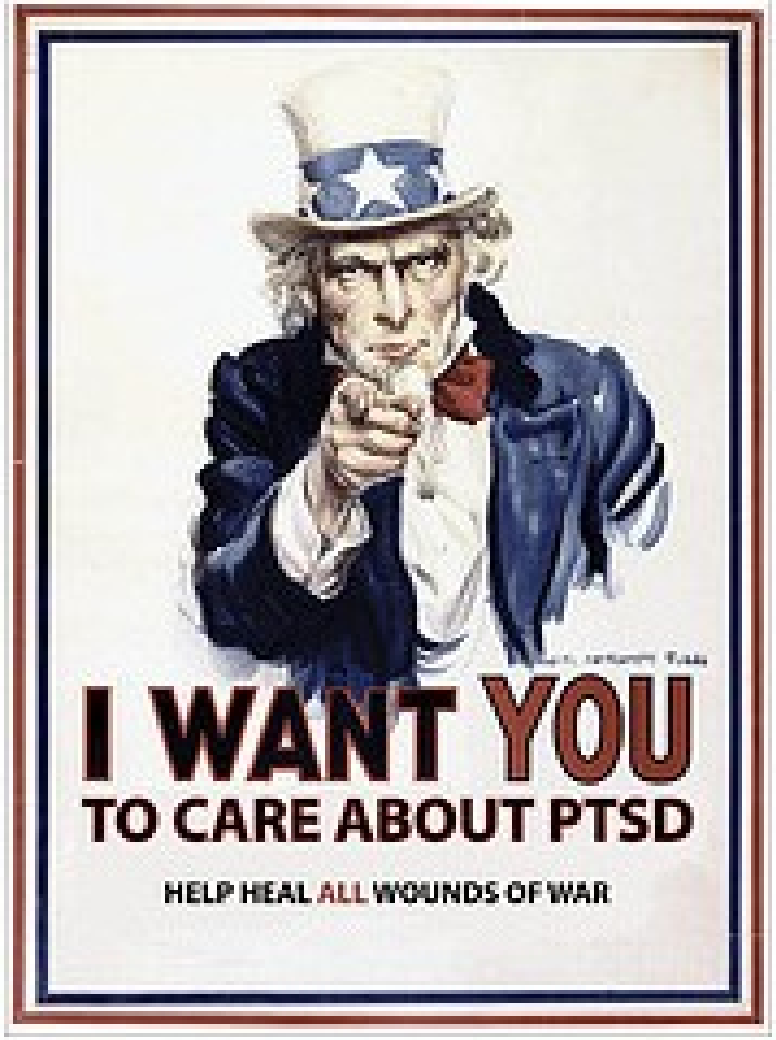
WCSRP: Lessons Learned

- **Staff & Patient selection** is critical
  - Holistic Model, Readiness, Support
- **Communication** is absolutely necessary
- **Stigma** must be addressed with CoC support
  - Ombudsman, IG, JAG, Education, CSF linkages
- **Program Evaluation** & Data Management resources required
- **Conclusion:** PTSD can become a



Questions?

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